MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 95

03176

CERTIFICATE OF DEATH

Reg. Dist. No. 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: St. Marys
City or town: Leonardtown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: St. Marys
City or town: Leonardtown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Edna J. Blackiston

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife: Andrew H.
8.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): August 15, 1886

8. AGE: Years	Months	Days	If less than one day
58			hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: John Brooks
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mollie Weems
15. Birthplace: Maryland

16. Informant: A. Howard Blackiston
Address: Leonardtown

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3/28/45 (month) (day) (year)
Cemetery or crematory: Our Ladys Chapel
Location: Medley's Neck, Leonardtown, Md.

18. Funeral director: P.B. Robinson
Address: Leonardtown, Md.

19. 3/26 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 25 19 45 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Mar 25 45 to Mar 25 19 45
and that I last saw h— alive on Mar 25 19 45

Immediate cause of death	DURATION
Acute Dilatation of Heart	30 min.
Due to Hypertension	9
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Jas. A. Carvalho M. D. or other
Address: Leonardtown Date signed: 3/26/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83)

03177

CERTIFICATE OF DEATH

Reg. Dist. No. 281

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A16

1. PLACE OF DEATH:
County: St. Marys
City or town: St. Inigoes
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: St Marys
City or town: St Inigoes Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Emanuel Carter

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Black	married

6 (b) Name of husband or wife: Ball

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
72			hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Farm

FATHER
12. Name: William Carter
13. Birthplace: unknown

MOTHER
14. Maiden name: Hester Carter
15. Birthplace: unknown

16. Informant
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-31-45 (month) (day) (year)
Cemetery or crematory: Zion Fair Cemetery
Location: St. Inigoes Md

18. Funeral director: E. L. Robinson
Address: Dameron Md

19. 3-29-1945 (Date rec'd by registrar) R. D. Bean M.D. Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 27 1945, at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 2 1945, to March 23 1945, and that I last saw h- alive on March 23 1945.

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 weeks
Due to Generalized Arteriosclerosis	
Due to	
Other conditions: Pneumonia at onset gradual Recovered.	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Mc Pokeland M.D. M. D. or other
Address: Pearson md Date signed 3-28-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03178

CERTIFICATE OF DEATH

Reg. Diat. No. 287

1. PLACE OF DEATH:

County: St. Mary's

City or town: Patuxent River, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Dispensary, NAS, Patuxent River, Md.

How long in hospital or institution? two hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: St. Mary's

City or town:
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Susan Marie FITCH

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): November 3, 1944

8. AGE: Years | Months: 4 | Days: 13 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Patuxent River, St. Mary's, Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business: None

FATHER
12. Name: Robert Burns Fitch
13. Birthplace: New Orleans, Louisiana

MOTHER
14. Maiden name: Edna D. Thoma
15. Birthplace: Chicago, Illinois

16. Informant: Robert B. Fitch
Address: U.S.N. Patuxent River Md. VR1

17. Burial, cremation, or removal: Burial at Date thereof: 3/17/45
Cemetery or crematory: Arch Memorial Park
Location: Long Island, N.Y. Short Hills N.J.

18. Funeral director: J. P. B. Robinson Jr.
Address: Leonardtown Md.

19. 3/17/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 16 March 1945, at 10:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from At intervals from Nov. 1944, to 16 March 1945
and that I last saw her alive on 16 March 1945

Immediate cause of death	DURATION
Atypical pneumonia	
Due to Cachexia associated with biliary fistula established.	
Due to Surgically because of congenital anomaly of bile passages.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results: Not done.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: E. G. Hamilton
E. G. HAMILTON, Lt. (MC) USNR
M. D. or other

Address: NAS, Patuxent River, Md. Date signed: 16 Mar. '45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

CERTIFICATE OF DEATH

03179

Reg. Dist. No. 287

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: St. Mary's County

City or town: Patuxent River, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Four (4) months

Hospital, institution, or street address where death occurred:
U.S. Naval Air Station

How long in hospital or institution? - -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Kentucky County: - -

City or town: Louisville
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2023 Murray Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: World War II ✓

3.(a) FULL NAME: FREEMAN, Jay Clay

3.(b) Social Security Number: 957 23 08

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White US	Married

8.(b) Name of husband or wife: Bonita J. Freeman

8.(c) If alive, give age: - - years

7. Birth date of deceased (mo., day, yr.): September 12, 1913.

8. AGE: Years	Months	Days	If less than one day
31	6	18	- hrs. - - min.

9. Birthplace: Mexico, Missouri
(Town, county, and state)

10. Usual occupation: Sailor

11. Industry or business: U. S. Navy.

FATHER
12. Name: - -
13. Birthplace: --

MOTHER
14. Maiden name: --
15. Birthplace: --

16. Informant: -
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof 4-2-45 (month) (day) (year)

Cemetery or crematory

Location: St. Charles, Missouri

18. Funeral director: P.B. Robinson's Funeral Home

Address: Leonardtown Md.

19. 4/2 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 30 March 1945 at 1710 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Not attended 19 ..., to ... 19 ...
and that I last saw him alive on 31 March 1945

Immediate cause of death	DURATION
DROWNING	- -
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 3-30-45

Where did injury occur? VR-8 Basin St. Mary's Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?): US NAS Patuxent River Md.

Means of injury: Drowning Injured at work? Yes.

23. SIGNATURE: H. K. Moore
H. K. MOORE, Lt. (MC) USNR
M. D. or other

Address: US NAS Patuxent River Date signed: 3-31-45

Evidence for change of age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

03189

CERTIFICATE OF DEATH

FILM No. G 9 4 MAY 15 1945

Reg. Dist. No. 787

1. PLACE OF DEATH:
County: St Marys
City or town: Leonardtown Md (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md County: St Marys
City or town: Leonardtown Md (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mary Dent Hancock
3.(b) Social Security Number

4. Sex: F 5. Color or race: W 6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Alvey Hancock
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Dec 10 - 1867
8. AGE: Years ~~78~~ 77 Months 2 Days 20 If less than one day ... hrs. ... min.
9. Birthplace: Great Mills St Marys Co Md (Town, county, and state)
10. Usual occupation: House wife
11. Industry or business
FATHER: 12. Name: Thomas Dent 13. Birthplace: St Marys Co
MOTHER: 14. Maiden name: Anna F Allston 15. Birthplace: St Marys Co
16. Informant: Mrs Catharine Dent Davis
Address: 515 Lyndhurst St Balto Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mch 5 1945 (month) (day) (year)
Cemetery or crematory: St Joseph
Location: Morganza Md
18. Funeral director: W C Mattingly Sons
Address: Leonardtown Md
19. 3/4 1945 (Date rec'd by registrar) Cavalier Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 2, 1945, at 3:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 1 1945, to Mar 2 1945
and that I last saw her alive on Mar 2 1945
Immediate cause of death: Chronic Myocarditis DURATION
Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Frank A. Cavalier M. D. or other
Address: Leonardtown Date signed 3/4/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (37a)

CERTIFICATE OF DEATH

03181

Reg. Diat. No. 282

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County St Marys
City or town Leonardtown Md Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County St Marys
City or town Leonardtown Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William Handy

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col	widower

6.(b) Name of husband or wife Not known
6.(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.) Not known

8. AGE: Years	Months	Days	If less than one day
47 Yrs	—	—	____ hrs. ____ min.

9. Birthplace St Marys Co
(Town, county, and state)
10. Usual occupation Laborer
11. Industry or business any Manual Job
FATHER 12. Name Not known
13. Birthplace
MOTHER 14. Maiden name Not known
15. Birthplace
16. Informant Mrs Elsie Ford
Address Leonardtown Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 14 45 (month) (day) (year)
Cemetery or crematory Our Lady of Mt Carmel Cemetery
Location Medleysneck St Marys Co Md
18. Funeral director Wm A Mattingley Sons
Address Leonardtown Md
19. 3/14 1945 C Greenwell Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 11th 1945, at 6 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 14th 1945 to Mar 11th 1945
and that I last saw h alive on Mar 6th 1945
Immediate cause of death Systemic Infection — DURATION
Due to Prostatic enlargement & disease
Due to Age
Other conditions
(Includu pregnancy within 3 months of death)
Major findings of operations ____ Date of op. ____
Autopsy results
PHYSICIAN: Please underline the cause to which death should bu charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE J F Greenwell M. D. or other
Address Leonardtown Md Date signed Mar 12 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

03182

Reg. Diat. No. 2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County: St Marys

City or town: Leonardtown Md Rural # 1
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: St Marys

City or town: Leonardtown R.F.D. # 1
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Joseph Edward Hill

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

B.(b) Name of husband or wife: Ida Wood Hill

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 6 - 1861

8. AGE: Years	Months	Days	If less than one day
83	10	14	..... hrs. ..... min.

9. Birthplace: Land Gates St Marys Co Md
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: —

FATHER
12. Name: —
13. Birthplace

MOTHER
14. Maiden name: —
15. Birthplace

16. Informant: Mrs Daniel Lacy
Address: Leonardtown Md R.F.D. # 1

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 23 1945 (month) (day) (year)

Cemetery or crematory: Sacred Heart Cemetery

Location: Bush Wood Md

18. Funeral director: W. C. Mattingly & Sons

Address: Leonardtown Md

19. 3/22 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 14 1945 at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1945 to March 14 1945

and that I last saw h— alive on Feb 1 1945

Immediate cause of death	DURATION
Chronic Nephritis	
Due to: Arterio-sclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Isaac A. Carvalho M. D. or other

Address: Leonardtown Date signed: 3/22/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03183

CERTIFICATE OF DEATH

Reg. Diat. No. 28

1. PLACE OF DEATH:
County: St. Marys
City or town: Mechanicsville, (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: St. Marys
City or town: Mechanicsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Sallie R. Holly

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	widowed

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 14, 1892

8. AGE: Years	Months	Days	If less than one day
52			hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Housekeeper
11. Industry or business

FATHER
12. Name: William Holly
13. Birthplace: Maryland

MOTHER
14. Maiden name: Rose Baker
15. Birthplace: Maryland

16. Informant: Edward Lyles
Address: Mechanicsville

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/31/45 (month) (day) (year)
Cemetery or crematory: St. Joseph
Location: Morganza, Md.

18. Funeral director: P. B. Robinson
Address: Leonardtown, Md.

19. 3/30 1945 Canalier
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 29th 1945, at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 20 19 Current 19
and that I last saw h alive on 19

Immediate cause of death	Apoplexy	16 m/18 Hrs
Due to	Arterial Sclerosis	
Due to	Syphilis	
Other conditions		

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Francis F Greenwell Coroner
M. D. or other
Address: Leonardtown Md. Date signed: Mar 30-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 74(a)

CERTIFICATE OF DEATH

03184

Reg. Dist. No. 287

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County St Mary's

City or town California Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 year

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County St Mary's

City or town California Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No. Route # 1 (If rural, give LOCATION) 1780376

2.(a) If veteran, name war World War # 1

3.(a) FULL NAME Alexander Jacobson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife Velma May Jacobson

6.(c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) Oct 8 - 1884

8. AGE: Years	Months	Days	If less than one day
58	5 -	9	....hrs. ....min.

9. Birthplace Riga Country Russia
(Town, county, and state)

10. Usual occupation Lumber man

11. Industry or business

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden name —
15. Birthplace —

16. Informant Mrs. Velma May Jacobson
Address California Md

17. Burial Date thereof March 20 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington Cemetery

Location Arlington Va

18. Funeral director W. C. Mattingley Son

Address Leonardtown Maryland

19. Mar. 20 1945 Cecil Alvey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17th 1945, at 9.30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 7 1945, to March 17 1945

and that I last saw him alive on March 16 1945

Immediate cause of death	DURATION
Anoxemia	Several days
Due to Chronic Leucaemia	Several months
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert T. Fuchs, M.D.
M. D. or other

Address Leonardtown, Md. Date signed 3/20/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17)

03185

CERTIFICATE OF DEATH

Reg. Diat. No. 287

1. PLACE OF DEATH:

County St. Marys

City or town St. Inigoes (Rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Marys

City or town St. Inigoes

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME James Robert Lee

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1920

8. AGE: Years 24 | Months | Days | If less than one day hrs. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation waterman

11. Industry or business

FATHER 12. Name Joseph K. Lee

13. Birthplace Maryland

MOTHER 14. Maiden name Julia Greenwell

15. Birthplace Maryland

16. Informant Clifton Lee

Address St. Inigoes

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/8/45 (month) (day) (year)

Cemetery or crematory St. Peters

Location Ridge, Md.

18. Funeral director Ernest L. Robinson

Address Dameron, Md.

19. 3/7 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 19 45 at 9:30P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 20 19 45 to March 6 19 45

and that I last saw h.im alive on March 4 19 45

Immediate cause of death Tuberculosis of joints and abdominal organs — DURATION 6 Mo

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Thos H Poteet M.D. M. D. or other

Address Pearson Road Date signed 3-7-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for change of age is shown on FILM No. G 9 4 MAY 15 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (166)

CERTIFICATE OF DEATH

03186

Reg. Dist. No. 287

1. PLACE OF DEATH:
County: St Marys
City or town: Jarboesville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? one month
Hospital, Institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1243 - 6th St S.W Washington D.C.
(If rural, give LOCATION)
2.(a) If veteran, name war: — ✓

3. (a) FULL NAME: Joseph Edward Mercer

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Widowed

8.(b) Name of husband or wife: Senoria Mercer
8.(c) If alive, give age: ... years
7. Birth date of deceased (mo., day, yr.): Jan 1st 1912

8. AGE: Years	Months	Days	If less than one day
33	3	16	... hrs. ... min.

9. Birthplace: Loudon Co Va
(Town, county, and state)
10. Usual occupation: Labor Paint
11. Industry or business: —

FATHER
12. Name: Charles Mercer
13. Birthplace: Loudon Co Va

MOTHER
14. Maiden name: Adie Costello
15. Birthplace: Loudon Co. Va.

16. Informant: Jessie W. Mercer
Address: 616 Calvert Court Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-19-45 (month) (day) (year)
Cemetery or crematory: St Pauls Cemetery
Location: Leonardtown Md
18. Funeral director: Wm C McKinley Sons
Address: Leonardtown Md
19. Mar 19 1945 (Date rec'd by registrar) Cavalier Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 17th 1945 at 2.35 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 17th 1945, to ... 19..
and that I last saw him alive on ... 19..

Immediate cause of death	DURATION
Hemorrhage	
Due to Gun Shot Wound	
Hemorrhage blood vessels	
Due to Gun Shot Kidneys	
Homicidal Guns	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Homicide Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: Francis F Greenwell Coroner
M. D. or other
Address: Leonardtown Md Date signed 3-17-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 77

03187

CERTIFICATE OF DEATH

Reg. Diat. No. 287

1. PLACE OF DEATH:
County St Marys
City or town Leonardtown Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution? 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newboro infants give residence of mother)
State Maryland County St Marys
City or town Abells Md
(If outside city or town limits, write RURAL aod give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Joseph Allen Morris

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Zella Morris
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 23 - 1866

8. AGE: Years	Months	Days	If less than one day
78	6	6	..... hrs. ..... min.

9. Birthplace Abells St Marys Co Md
(Town, county, and state)
10. Usual occupation Waterman
11. Industry or business
12. Name of father John Morris
13. Birthplace of father St Marys Co
14. Maiden name of mother Jennie Cheseldine
15. Birthplace of mother St Marys Co
16. Informant John Francis Morris
Address 25-35 West Lafayette Ave Balto Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof March 6 1945 (month) (day) (year)
Cemetery or crematory Sacred Heart Cemetery
Location Bush Wood Md
18. Funeral director W. C. Mattingley Sons
Address Leonardtown Md
19. 3-3-1945 (Date rec'd by registrar) Camalier Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3 1945, at 4 20 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 21 1945, to March 3 1945
and that I last saw h alive on March 3 1945

Immediate cause of death	DURATION
Uremia - Arteriosclerosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Francis G. Camalier M. D. or other
Address Leonardtown Date signed 3/3/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

VS A15

Evidence for verification of sex of deceased is shown on Film No. G94 - May 15, 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03188

Reg. Dist. No. 281

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: St. Mary's
City or town: Rural (Great Mills)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: St. Mary's
City or town: Great Mills
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Samuel Elby Queens

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): ? 1876

8. AGE: Years: 68 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: Samuel Queens
13. Birthplace: Maryland

MOTHER
14. Maiden name: Sarah Burroughs
15. Birthplace: Maryland

16. Informant: William Sickle
Address: Great Mills

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3/15/45 (month) (day) (year)
Cemetery or crematory: Holy Face
Location: Great Mills

18. Funeral director: C. B. Robinson
Address: Leonardtown, Md.

19. March 14 1945 (Date rec'd by registrar) — Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 13 1945 at 10:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 10 1945, to March 13 1945; and that I last saw h— alive on March 13 1945.

Immediate cause of death	DURATION
Cerebral Hemorrhage	3 days
Due to	
Due to	
Other conditions: Epilepsy	60 years

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: D. J. Bean M.D.
M. D. or other
Address: Great Mills, Md. Date signed: 3/14/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-21)

03189

CERTIFICATE OF DEATH

Reg. Dist. No. 287

1. PLACE OF DEATH:
County: St. Marys
City or town: Leonardtown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
St. Marys Hosp.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: North Carolina County: Mecklenburg
City or town: Charlotte
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: John Irwin Ritch

3. (b) Social Security Number: 253-26-8947

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Madeline
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 1st 1886

8. AGE: Years	Months	Days	If less than one day
58			hrs. min.

9. Birthplace: North Carolina (Town, county, and state)
10. Usual occupation: Civil engineer
11. Industry or business

FATHER
12. Name: Duncan T. Ritch
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Elizabeth M. Lemmond
15. Birthplace: North Carolina

16. Informant: Madeline Ritch
Address: 1949 Avondale Ave. Charlotte, N.C.

17. Transportation (Burial, cremation, or removal. Which?) Date thereof 3/3/45 (month) (day) (year)
Cemetery or crematory: Elm Wood
Location: Charlotte, N. C.

18. Funeral director: P. B. Robinson
Address: Leonardtown, Md.

19. 3/3/1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 3 19 45 at 12:45 PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb. 18 19 45 to March 2. 19 45 and that I last saw him alive on March 2. 19 45

Immediate cause of death: Cerebral Hemorrhage — DURATION: 3/25/45
Due to: —
Due to: Arterial hypertension — DURATION: ?
Other conditions: Auricular fibrillation — DURATION: March 1945
(Include pregnancy within 3 months of death)

Major findings of operations: none done
Date of op.
Autopsy results: none done
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Alexius C. Wedd M.D. M. D. or other
Address: Chaptico Md Date signed 3/4/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 103

CERTIFICATE OF DEATH

03190

Reg. Dist. No. 86

1. PLACE OF DEATH:
County: St. Mary's
City or town: Rural Oakley
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: St. Mary's
City or town: Rural Oakley
(If outside city or town limits, write RURAL and give nearest town)
Street No. Md
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME John Stewart
3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Cd	Single

6.(b) Name of husband or wife: None
6.(c) If alive, give age ...... years
7. Birth date of deceased (mo., day, yr.) 7-4-63

8. AGE: Years	Months	Days	If less than one day
81	11	13	...... hrs. ...... min.

9. Birthplace: Kings Springs
(Town, county, and state)
10. Usual occupation: Unknown
11. Industry or business
FATHER 12. Name: Phillip Stewart
13. Birthplace: Md
MOTHER 14. Maiden name: Eliza Lacy
15. Birthplace: Md
16. Informant: Francis Stewart
Address: 427 R St. N.W. Wash.
17. Burial Date thereof 3-22-45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Laurel Heart
Location: Bushwood
18. Funeral director: Rose & Welch
Address: Chaptico Md
19. 3-21-1945 R. V. Palmer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1945 at 5 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-29 1945 to 3-20 1945
and that I last saw him alive on 3-13 1945

	DURATION
Immediate cause of death: Coma Uremia	
Due to: Lobar pneumonia	7 ds.
Due to:	
Other conditions: Emphysema lung	

(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Robt. V. Palmer
M. D. or other
Address: Leonardtown Md Date signed 3-21-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

03191

CERTIFICATE OF DEATH

Reg. Diat. No. 282

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: St. Mary's

City or town: Leonardtown, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? [illegible]

Hospital, institution, or street address where death occurred: St. Mary's Hospital

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: St. Mary's

City or town: Leonardtown, Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Joseph Henry Williams

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Rose M. Williams

6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): Oct. 6th 1886

8. AGE:

Years	Months	Days	If less than one day
58	4	24	hrs. min.

9. Birthplace: Laurel Grove, St. Mary's Co. Md

(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER

12. Name: William H. Williams

13. Birthplace: St. Mary's Co. Md

MOTHER

14. Maiden name: Alice Wettingly

15. Birthplace: St. Mary's Co. Md.

16. Informant: Mrs. Rose M. Williams

Address: Leonardtown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-5-45 (month) (day) (year)

Cemetery or crematory: St. Aloysius

Location: Leonardtown, Md

18. Funeral director: W. C. Mattingly Sons

Address: Leonardtown, Md.

19. 3/4-45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 2nd 1945, at 4:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 15 1945, to March 2 1945

and that I last saw him alive on March 2 1945

	DURATION
Immediate cause of death: Cerebral Hemorrhage	2 days
Due to: Chronic Hypertension	Several years
Due to: Chronic Nephritis	Several yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Robert V. Fuchs M.D.

M. D. or other

Address: Leonardtown, Md. Date signed 3/5/45